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RESEARCH ARTICLE

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## PATIENT SAFETY CORE: IMPLEMENTATION ASSESSMENT

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### ABSTRACT

**Objective:** to evaluate the implementation of the Patient Safety Core in a maternity hospital in the metropolitan region of Belo Horizonte (Minas Gerais) under the perception of the multidisciplinary team. **Method:** this is a qualitative and quantitative exploratory-descriptive study conducted in 2019 in a public maternity hospital in Betim. The Safe Attitudes Questionnaire was applied to collect quantitative data and the focus group technique was used to collect qualitative data with members of the multidisciplinary team of the maternity hospital. For the qualitative data analysis, the Content Analysis method was used, and for the quantitative data, a descriptive analysis related to the Safe Attitudes Questionnaire was performed. **Results:** the data analysis emerged from the association between the variables collected by qualitative and quantitative methods in order to complement the information extracted in the survey, broken down into five analytical categories: 1st category: Safety environment x Patient safety culture; 2nd category: Teamwork environment x Job satisfaction; 3rd category: Working conditions x Perception of stress x Management; 4th category: Correct patient identification x Patient safety culture and 5th category: Safety in medication administration x Patient safety culture. **Conclusion:** it is understood that the staff is more alert regarding patient safety, but the organization's structuring factors are still incipient to ensure a strong safety culture.

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## INTRODUCTION

Pregnancy and childbirth are critical moments that determine the future health and well-being of mother and baby. One of the major issues surrounding patient care in the maternal and neonatal context is improving safety in maternity care, working collaboratively, introducing and disseminating innovation, reducing unwarranted variation, and creating a culture of learning from mistakes and excellence. Maternity care remains associated with preventable harm that can result in severe disability and profound distress for women, their children, and families and high costs to health systems. As in other areas of health care, improvement efforts generally focus on implementing and evaluating specific interventions or identifying contextual characteristics that can be generative of safety, such as structures, processes, behavior, practices, and values, but the dialogue between these two approaches is still challenging (Sousa, 2020). The implementation of the Safety Core in health organizations became a mandatory determination with the publication of the Collegiate Directive Resolution (CDR) number 36, of the Ministry of Health, in 2013. However, establishing a core focused on the promotion of safe care and also on the excellence of guidance to patients, families, and other people in the social circle of inpatients is still a challenge for health professionals (Brasil, 2013).

In Brazil, patient safety follows the global trend, being treated as an essential part of the multidisciplinary health team's care, which aims to prevent preventable errors and harm to the patient in the various hospital organizations, among them, the maternity hospitals. There is a need to improve the safety and outcomes of maternity and neonatal care, reducing maternal and neonatal adverse events and providing a high-quality healthcare experience for all women, infants, and families in maternity and neonatal units. It is about contributing to the national ambition to reduce the rates of maternal and neonatal deaths, stillbirths, and brain injuries that occur during or shortly after birth (Salgado et al., 2017; Strefling et al., 2018; Bourguignon et al., 2020; Dobrzykowski et al. 2016). Brazil has revised the goals of reducing maternal mortality and neonatal and infant mortality, defined in the Sustainable Development Goal (SDG), pertinent to health and well-being, to adjust them to the national reality. The goal regarding maternal mortality has been redefined to up to 30 deaths per 100,000 live births; the global goal for 2030 is to have less than 70 deaths (Organização das Nações Unidas, 2021). It is observed, however, that health professionals who prioritize patient safety as a risk management tool to reduce losses in health organizations are still rare. Moreover, in a preliminary analysis, it is possible to notice that the subject of patient safety has, in general, good receptivity from health professionals.

However, this acceptance only occurs under superficial aspects, reinforcing the existence of misinformation, by some, on the subject and its practical applicability in the professional routine in maternity hospitals. The first significant publication on patient safety was the Institute of Medicine's report entitled "To Err is Human", in 1999. The understanding of most professionals is still distorted with a mistaken sense of safety and a restrictive and defensive posture in dealing with failures in patient care (Fernandes & Vilela, 2014). The relevance of this research is justified by the importance of implementing a Patient Safety Core (PSC) that can support improvements in maternal and neonatal care processes. Considering the importance of the professionals' participation in this process of implementation and consolidation of the PSC in a maternity hospital and the scarcity of studies related to this perspective, we evaluated the Implementation of the Safety Core in a maternity hospital under the perception of the multidisciplinary team

## MATERIALS AND METHODS

This is a qualitative and quantitative, exploratory-descriptive study, mediated by the action research method. It is a case study carried out at the Public Maternity Hospital of Betim. This institution was chosen because it has recently implemented the PSC. The study was part of the research project of the Professional Master in Health Services Management entitled "Evaluation of the implementation of the patient safety core in a maternity hospital", which aims to evaluate the implementation of the PSC in maternal and neonatal care from the perspective of the multidisciplinary team of the Public Maternity of Betim (MG). The professionals of the referred institution were selected to participate in the study, and the professionals were invited, considering both the care team and the diagnostic and administrative support team. We chose to invite both the team that works directly in assistance and the administrative and support team, because it is known that when it comes to patient safety, the whole team is involved and, from a problem in the equipment to a medical prescription error, can put patient safety at risk. The inclusion criterion was: to be a professional of the public maternity hospital with a permanent or contracted position. It was observed that all participants consented to their participation through the Free and Informed Consent Term (FICT). Data was collected in the month of December 2019, in two stages. In the first half of the month, quantitative data were collected by applying the Safety Attitudes Questionnaire (SAQ) 'Safety Attitudes Questionnaire', translated and adapted for Brazil in 2011, by Rhanna Emanuela Fontenele Lima de Carvalho, in her doctoral thesis entitled "Cross-cultural adaptation of the Safety Attitudes Questionnaire for Brazil - Safety Attitudes Questionnaire". The instrument was designed by Bryan Sexton, Eric Thomas and Robert Helmreich, in the United States, and is available, free of charge and electronically, in the English version, validated for application throughout the national territory. This instrument is composed of 36 questions, which refer to the perception about patient safety, allowing the measurement of the patient safety culture with the professionals of the institution where it is being applied. It measures the perception of health professionals about the safety culture through six domains: 1. teamwork environment; 2. safety environment; 3. job satisfaction; 4. perception of stress; 5. perception of management and 6. work conditions (Carvalho & Cassiani, 2012). A total of 122 questionnaires were handed out and 69 were returned; of these, only 61 had the signed FICT and, for this reason, were considered valid for the study. To avoid the questionnaires remaining with the FICT and the possible identification of the participants, the returned questionnaires were stored in a folder and the signed FICTs were stored in a brown envelope with no external identification. In the second half of December 2019, qualitative data collection was performed using the focus group technique. These groups were conducted based on guiding questions about the key domains for the construction of the diagnosis of patient safety culture: teamwork environment, job satisfaction, professional perception of the unit's management, safety environment, working conditions, and stressors.

The development of the research was guided by the ethical precepts set forth in Resolution No. 466/12 of the National Health Council in

accordance with the Guidelines and Standards Regulating Research Involving Human Beings (Brasil, 2012). The study was approved by the Ethics Committee of the Federal University of Minas Gerais (COEP) on September 17, 2019, under CAEE: 18928619.3.00005149 and Opinion number: 3579,577 and by the Research Ethics Committee of the research reference municipality (REC) on November 20, 2019, under CAEE: 18928619.3.30015651 and Opinion number: 3,714,568. After final approval of the project, data collection was initiated at the Betim Public Maternity Haydée Espejo Conroy. The servers were invited to participate in the study and the acceptance had as a prerequisite the signature of the FICT in two copies, one with the main researcher and the other with the participant. The data was tabulated and analyzed according to its nature, and for the qualitative data analysis, it was used the Content Analysis, technique employed as a set of techniques for communications analysis, with the main focus on the interpretation of the content of the conversations, starting from the principle of recording, transcribing the data and building the analysis categories (Bardin, 1977). For statistical analysis, data was collected using the STATA software program (Stata Corporation, College Station, Texas), version 12.0, and graphed in Excel 2016, considering a 5% significance level.

## RESULTS

A total of 122 questionnaires were distributed, but a total of 69 (56.55%) were returned. It was observed in the analysis that only 61 (87.14%) questionnaires were valid and the rest (9=12.85%) were incomplete or incorrectly filled out. The focus groups were attended by 39 staff members of the institution studied, with predominant participation of the Nursing team. Of the 39 employees, eight were nurses (20.51%); 25 were nursing technicians (64.10%); two were pharmacists; three were administrative staff, and one was an X-ray technician. It is noteworthy that no medical professional agreed to participate in this stage of the research, claiming lack of time. In the total number of participants in the focus groups, 35 (89.7%) were female and four (10.3%) were male. To perform the content analysis, the interviews were transcribed, read thoroughly, separated by color and grouping similar ideas, which made possible the coding of all those that originated common themes, which are the Meaning Units. The emphases given by the participants in some passages of their speeches were bolded, aiming, in this way, to facilitate the understanding of the meaning given by them in their speeches. The following abbreviations were used to characterize the groups of participants: FG1 - Focus Group 1; FG2 - Focus Group 2; FG3 - Focus Group 3 and FG4 - Focus Group 4, followed by the abbreviation of the professional category - Nursing technician (TEC), nurse (NUR), administrative (Adm), pharmacist (PHA). Table 1 shows the information about the participants.

**Table 1. Profile of the professional categories participating in the research Betim (MG), Brazil, 2020**

Professional Categories	Number of Participants of Questionnaires	%	No. of Focus Group Participants	%
Nurses	11	18.03%	8	20.51%
Nursing Technicians	30	49.18%	25	64.10%
Doctors	4	6.55%	0	-
Physiotherapists	1	1.63%	0	-
Pharmacist	2	3.27%	2	10.25%
Administrative and support	12	21.31%	4	20.50%
Total	61	100%	39	100%

Below is a compilation of the data according to the responses in each domain of the Safety Attitudes Questionnaire and the content analysis of the focus groups. From this synthesis, five analytical categories have emerged:

**1<sup>st</sup> Category:** Safety environment x Patient safety culture;  
**2<sup>nd</sup> Category:** Teamwork environment x Job satisfaction;

3<sup>rd</sup> Category: Working Conditions x Stress Perception x Management;

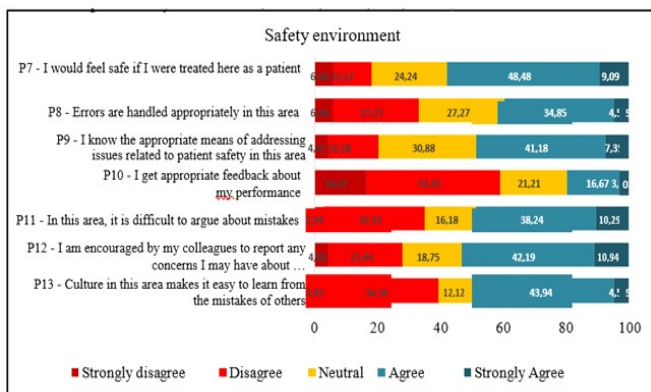
4<sup>th</sup> Category: Correct patient identification x Patient safety culture;

5<sup>th</sup> Category: Drug Administration Safety x Patient Safety Culture.

**Category 1: Safety environment x Patient safety culture**

The diagnosis of the patient safety environment in the institution under study was obtained by answering the Safe Attitude Questionnaire. This instrument measures the perception of health professionals about the safety culture through six domains: 1. teamwork environment; 2. safety environment; 3. job satisfaction; 4. perception of stress; 5. perception of management and 6. working conditions. The scores are counted in the following way: the questions are ordered by domains; the answers of the questions in each domain are summed, and divided by the number of questions in each domain. The value of the instrument varies from zero to 100, where zero corresponds to the worst perception of safety attitudes by health professionals and 100, to the best perception. Positive values are considered when the total score is equal to or greater than 75 (Carvalho & Cassiani, 2000).

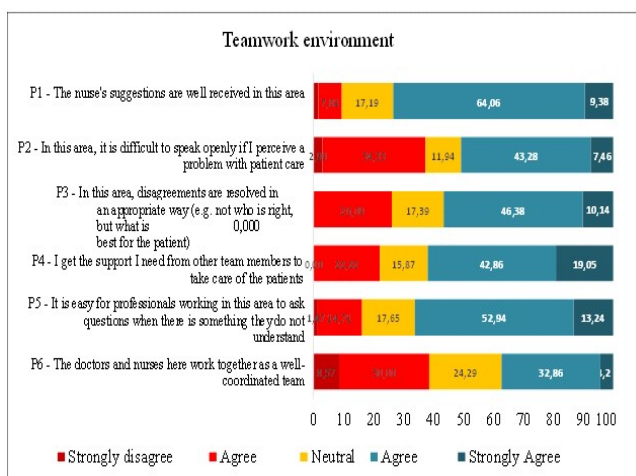
According to graph 1, below.



Extracted from: own authorship, December 2019.

**Graph 1. Safety environment, MPMB, Betim, MG, Brazil**

**Category 2: Teamwork environment x Job satisfaction:** It is described, in general, that the participants agreed with the statements referring to the domain Teamwork environment and positioned themselves favorably regarding satisfaction and pride in working in the institution and in the health area, as shown in charts 2 and 3.



Extracted from: own authorship, December 2019.

**Graph 2. Teamwork environment, MPMB, Betim, MG, Brazil**

**Category 3. Working Conditions x Perception of Stress x Management:** The Perception of Stress and Working Conditions domains presented variations in scores from 44.6% to 69.8%, being

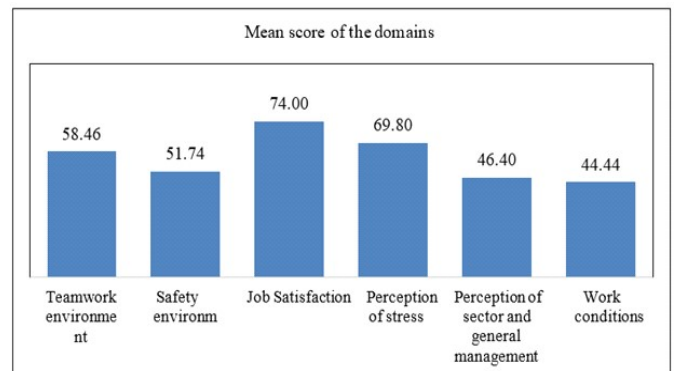
that working conditions reached the lowest score, which was 44.6%, and the Perception of Stress was 69.8%, showing that poor working conditions increase the perception of stress.



Extracted from: own authorship, December 2019.

**Graph 3: Job satisfaction, MPMB, Betim, MG, Brazil.**

In general, poor working conditions and a management considered weak, with the average score of 46.40%, increase the professionals' stress and directly compromise patient safety. Data presented in graphic 4. It becomes expressive that categories 4 and 5, although not contemplated in the graphics, followed the basic guidelines of the patient safety protocols, such as patient identification and medication administration, according to the speeches of the participants addressed in the discussions.



Extracted from: own authorship, December 2019.

**Graph 4. Mean score of each domain, MPMB, Betim, MG, Brazil**

## DISCUSSION

It is pointed out by the research result that, in the studied health institution, evaluating the implementation of the PSC is a process in which the qualitative data collection complemented the study information, allowing to capture the perceptions of the servers about the patient safety theme and the implementation of the PSC. Safety environment can be measured by means of questionnaires and is amenable to change in the short term. Safety culture, on the other hand, is more complex and describes the institution's ingrained perceptions, behaviors, and attitudes about safety culture that cannot easily be changed (St. Pierre, 2013). It is detailed in the results obtained during the focus groups that, when evaluating the implementation of the PSC, it was detected that there were changes in the professionals' postures regarding the safety environment and a process of action and reflection on patient safety was started, as shown below.

*Yes, I think that, at least, we started to discuss more about patient safety, to discuss more, to research or, at least, for those who didn't know, to reflect, it caused, at least, a... instigated a reflection on the subject with the points that were made with the technical team. (FG1-TEC 1)*

*I think that, from the point of view of the organization, of the work process, the routine of the transition of care has helped us a lot, which is an organization that transforms the service, transforms the work process, so the values, they are all contained there, which integrates this change in the work process. (FG1- NUR 3)*

*I think that the information was good, in our defense, in our learning, you know, for my safety and the patient's, the support for us. (FG2- NUR 1)*

It is observed in this study that the safety culture involves behavior change, team awareness, collaboration between professionals and, above all, the safety of each professional. According to the reports, the safety culture is a process that requires a long term investment to be rooted in the work environment, which can be observed in the following statements.

*The change of culture, the change of paradigm is a process, we don't change overnight, it's collective, it's together, in a work community, we have to understand this as a process, it's one commenting with the other, it's one helping the other, it's one pushing the other where they see they are not there, it's us forming a chain. (FG1- TEC 1)*

*The safety of the professional permeates all levels of the maternity hospital, not only in the assistance, but also in the doctors in general, you know? (FG3- NUR 6)*

*What it brought to me, in relation to this awareness work, at least, as you listen to the patient's safety, the thing gets into our brain, and then, with time, we change our behavior. (FG3- TEC 9)*

Health care organizations have two obstacles to strengthening a safety culture: the view that it is enough to train the health professional not to make mistakes, and the other belief, still rooted in the culture of punishment, that stigmatizes the error, attributing it to the individual's incompetence (World Health Organization, 2009). The discrepancy between high reliability organizations and healthcare organizations is noteworthy, since healthcare organizations tend to believe that everything will go right, focus on the efficiency of the system, believe that professionals know everything, and have hierarchy gradients among professionals. On the other hand, high reliability organizations have the belief that something can go wrong, focus on the reliability of the system, humility to understand and learn what is not known, and behavior that values teamwork (Kohn et al., 2000). Regarding the item that addresses the issues concerning the just culture in the institution (P11), the results are weak and present that 68.71% disagree that it is difficult to discuss the errors in the institution. In contrast, the culture of learning from mistakes was 48.53%, which allows us to affirm that discussing mistakes is positive, however, learning from mistakes is a weak perception on the part of the team. In corroborating this statement, the following extracts show that change must occur so that safety is guaranteed not only for the patient, but also for the team.

*Because, in the health area, you always have to improve a lot of things, so, you can't say "ah, I already know everything", so, something is always changing and, that's why it's important to be alert, because in health, it's always changing. (FG3- TEC 7)*

*It's what is happening with the employees that are adjusting safety, they are doing it to be able to adjust to this, and see if it works, for the patient, it's safer and everything and the management doesn't see that this is reciprocal. But, well, we have to have this reading because, really, we don't invest in something that we don't want to change. (FG3- NUR 4)*

*But it is a constructive thing that we are doing, it is not just for us to apply here, we work in other places, we can apply our knowledge in patient safety, it is a global thing for us that are here in the maternity ward to do, because we can absorb more knowledge that we can also work on, right on top of it, and we can improve. (FG3- TEC 8)*

When it comes to healthcare institutions, the concept of patient safety is to prevent the occurrence of errors and harm, to avoid exposing patients to injury, side effects, and/or death from adverse events. In this regard, harm can be from lack of proper care, delay or failure in diagnosis, or complications from a misadventure during treatment. In this sense, patient safety should be a care free of failures and threats, considering the human resources available, materials and equipment,

and the institution's safety protocols (Acuri, 1991). Hierarchy gradients are presumed in healthcare organizations and consist of the psychological distance between the worker and his supervisor. However, in health care organizations, where teamwork and clear communication are essential, hierarchical or authority gradients cannot cause intimidation or fear of punishment among their members, as this may compromise the safety culture in the organization (Wachter, 2013). It is perceived that, in the institution studied, the notification of adverse events and the observation of near misses are a concern of the team, understood as part of a process that contributes to improved care, greater patient and team safety. However, it is noted that the posture of the team is more focused on taking immediate action to solve the reversal of the near misses than to continue the notifications, because they have not yet assimilated the importance of notifications as tools to learn from errors, as observed in the following statements.

*Adverse events, so, what happens, many people don't go, don't communicate, then it ends, because then it doesn't change, because it's easier to say the right thing, that is, even the colleague there, it's not to turn him in, it's for the question of improvement. (FG3- TEC 15)*

*We can count on it, we have more access, notifying about wrong things, if it gives you security, you can clarify what is happening, so, everything written down, I think is the right thing, understand? Because, if there is something right, if it goes wrong, you go there, it happened this, this and this, so, this is having a support, just like that. (FG3- TEC 10)*

*It's about doing the right thing, at the right time, there's no point in doing the right thing, once it's gone, it has no effect. (FG3- NUR 2)*

*It has this feeling that it's going to increase my work, I've already worked so much, I'm going to work more, it doesn't come with this intention to increase work, in fact, it is to simplify. (FG4- TEC 21)*

*Improve the quality of the work, if there is a bad part, once, twice, you have to go back to repeat it, to redo it, or else there is no way to correct it, in our area, many mistakes are not even corrected (...) I have to do this, it is necessary that it is done, some care that, many times, we kind of skip to shorten the time, so, this is very interesting. (FG3- TEC 10)*

Organizations that apply a culture of punishment and blame individuals to correct a mistake or an occurrence of an incident, or near incident, make the environment conducive to the weakening of the safety culture in the institution. In this sense, the professional is afraid to report or notify the event, preventing or hindering the identification of security problems, losing the company's opportunity to learn from the mistakes that occurred. Linked to the concept of patient safety, the systems approach is against the punitive culture. The principle of the systems approach is that individuals make mistakes, to err is human nature; mistakes are expected and are consequences and not the cause. Changing the human condition is not possible to stop mistakes, but it is possible to build a system of the institution's functioning as a defense mechanism to prevent mistakes from happening. Just Culture is premised on learning from mistakes and using incident reports or notifications for organizational learning (Reason, 2003). In the systemic approach, there is a relationship between adverse events and the existence of deficiencies in the structures and work process and that the incidents are the consequence of a trigger of systemic factors such as the organization's culture, work practices, management approach, risk prevention and the installed capacity to learn from mistakes based on safety incident record systems (World Health Organization, 2009). A just culture is able to distinguish between human error, risky behavior, and reckless behavior through root cause analysis of adverse events or reported incidents. In fair culture, the focus is on incident behavior rather than the severity of the incident, strengthened by a culture of trust, learning, and accountability to minimize negative impacts and maximize the learning process (Dekker, 2016). It is a challenge for

leadership to implement and sustain a well-established consequences policy in which intentional behaviors or acts that endanger or threaten patient safety are appropriately punished. Leadership must have an ethical and legal commitment to the people assisted in the institution. The just culture of learning from mistakes cannot override the need for civil, criminal, and/or ethical accountability. There is a fine line between just culture, blame culture, and accountability. It is complex to separate expected failures from transgressions. The commitment of front-line leaders to the appropriate approaches for each type of event that occurs in the institution is paramount to promoting and sustaining a culture of safety, improving and maintaining reliability in the institution (Biopsin, 2019). In general, the participants agreed with the statements referring to the teamwork environment domain and positioned themselves favorably on the Satisfaction and pride in working in the institution and in the health area. In all items of the "Job Satisfaction" domain, a favorable result was obtained above 80% of the answers, with the exception of professional morale, which obtained a favorable result above 35%. A brief concept of morals reveals that it is a system of norms, principles, and values that guide both individual and collective behavior in a society and regulate the relationships between individuals and between individuals and society in a non-coercive way. It has a historical and social character that is freely embodied at the level of intimate conviction (Figueiredo & Guilhem, 2008). The implementation of the PSC involves the incorporation of practices focused on the goals established by the World Health Organization (2009) to improve patient safety in healthcare organizations. In this study, it was observed that patient safety goals, such as patient identification and safety in medication administration, were widely scored, which is justified because it is a daily practice of Nursing and the predominance of the participation of the Nursing team in the study (World Health Organization, 2009).

The team's adherence to the aforementioned goals is evident in the participants' speeches about the importance of correct patient identification, with a focus on improving safety and support for the professional. Regarding patient identification, the study participants reported the importance of this care, highlighting the risks to which the patient and the staff are exposed if it is not performed accurately.

*Before, maybe, we didn't give so much importance, you know, in relation to this, I think we were much more attentive to this, patients with the same name, in the same ward, so, I think we ended up being more connected in relation to this. (FG1- TEC 1)*

*I also found it interesting that it showed the risk of not identifying the patient, the time of medication and everything else, and I don't remember if it was right after he went to the nursery, to see if there were mothers with the same names, right, it was like a kind of amazing thing that was discovered very quickly, right, so it was just like that, right, so, I found it very interesting for us to be aware like that. (FG1- TEC 5)*

*I see that the team is more committed in relation to this, I think, in relation to the identification, the double name, when I see, "Our Lady", there are two of the same names here, the same thing has already happened, right, with us with three mothers. (FG1- TEC 2)*

*And there is another one, a little identification plate that you will have with each patient, every differentiated, minimal and personal situation of this patient, will be on the plate. (FG1- NUR 3)*

Some recommendations regarding patient identification are highlighted, such as the responsibility of health professionals in patient identification, the use of at least two identifiers to confirm the patient's identity, and in Pediatrics and Neonatology units, it is recommended to use the name of the child's or newborn's mother. In addition, promote alertness to distinguish patients with the same name, verify the legibility and integrity of the information and not use bed number, gender, diagnosis or age to identify the patient (World Health Organization, 2009). Patient identification is a practice that requires low financial investment cost and high involvement of the multidisciplinary team with patient safety measures. However, it is

extremely important in management and health care processes, because incidents, errors or adverse events related to patient identification may have irreversible outcomes (Bates et al. 2009). In view of this prerogative, the WHO (2009) determined strategic measures for the correct identification of the patient, among which we highlight placing and maintaining the wristband during the entire period in which the patient remains in the institution, that is, from admission to discharge; involving all professionals who perform patient care in checking the data on the wristband before any care or procedure; involving both the patient and the family in the identification process, in an active way, in addition to establishing protocols in health institutions, preventing particularities, such as homonyms, abbreviations or impossibility in the use of the wristband (World Health Organization, 2009). Although it is noticeable the change in professionals' posture regarding patient identification as a strategy to improve patient safety in the institution, there are flaws in the process that deserve a more robust investment. Studies have pointed out failures in relation to patient identification through the mother-child binomial wristband related to the process, such as the very execution of professionals and structural issues. There is a need for intervention throughout the process, such as the implementation of a protocol, technological investment, and stimulating the commitment of the multidisciplinary team to the entire identification process and, consequently, to patient safety (Tase & Tronchin, 2015).

*Despite the fact that we still have a gap, because we know that it is extremely important to identify the patient at the front desk, to have the patient's mother written down in the note, and to have all the data correct, and they already come, already identified in all the stages, right, this is what we lack, because we don't have wristbands. (FG1- TEC 3).*

*For example, patient identification, people don't put it on because they are lazy or because they don't have a pen, or one thing or another, and it's very sad when you see that it's because of laziness, because it makes a difference, because, for example, you enter the ward, you look, you see the name, you ask the person, this is very important, this works on patient safety, so, there is something that, for example, is being discussed here. (FG3- NUR 5)*

*The identification of the NB and the mother leaves much to be desired, this bracelet, if you drop a drop of alcohol on it, everything disappears, it's all over, and it's of terrible quality. (FG3- TEC 7)*

*And another thing, it's of terrible quality, it's dangerous, the bracelet on the little leg, as some of you have already said, when the baby is like this, it hurts the baby's skin, on the little foot, it's dangerous, you have to cut it off and take it off. (FG1- TEC 3)*

*Then you finish this one, you make the one with string, you run the risk of cutting your arm. (FG2- TEC 6)*

Providing safe patient care translates to reducing the risk of harm related to the care provided by health care professionals. Identifying the patient correctly is an action that has a significant impact on reducing preventable failures (Lima, 2014). It is observed in this study that another patient safety goal that was well discussed and scored was safety in medication administration. There was effective participation of the Nursing and Pharmacy teams. They made the intervention of removing the high surveillance drugs stored on display, together with other drugs frequently used in the sectors. This removal had already been proposed other times, however, without success.

Safety in drug therapy can be understood as providing drug therapy free of harm or accidents arising from the entire medication process, from the indication, prescription, administration to the monitoring of desired or side effects, with the basic premise of preventing or minimizing, effectively, the damage resulting from this process (Instituto para Práticas Seguras no Uso de Medicamentos, 2017).

*[...] in the beginning of everything, it was the patient's medication, the correct routes of administration in the case of a nursing*



*technician working with the patient, seeing the reactions, right, in the administration, even more concerned with adverse reactions at the time of medication administration, and I think so, that is a revolution in the area of Nursing. (FG1- TEC 2)*

*The issue of medications, which are taken there, medication time, amount of medication, reinforcing the importance of patient safety, the patient's health, all the patient's information, the medication that is taken, how it is taken. (FG1- TEC 1)*

*There have been situations like that, that I myself had forgotten and, at that moment, to do magnesium sulfate in the pre-delivery, and then a colleague arrived with the infusion pump already set up, in the solution, with all the dripping and incorporated that in a very nice way, and the obstetricians stayed there, in that thing, and insisting, where, where, where, you haven't done it yet, it's here in the pump, it's doing it, but it doesn't do it, it's not like that, it's done with a syringe, no, now it's done in the infusion pump it's safer. (FG3- NUR 4)*

*Because the user was very serious, you know, so, it's that thing, everyone is on top of it, and the colleague had incorporated the orientation very well, it was very unforgettable, then, I get like this, these people who are prescribers, they are at the margin of the process, not very participative, with him, he is the prescriber, I want it that way, even if it escapes the protocol. (FG3- NUR 4)*

The errors arising from the drug therapy process are the consequence of several factors. Among these, one is related to the unpreparedness of professionals in relation to technical-scientific procedures that involve the prescription and administration of medications. These professional attitudes can lead to errors and, consequently, compromise patient safety (Carvalho & Cassiani, 2000).

Because it is the beginning of the process, inappropriate drug prescriptions can lead to problems throughout the chain and can cause harm to the patient (Miasso et al., 2006). Law # 5.991/1973 establishes requirements that must be followed for the preparation of drug prescriptions: the prescription must contain the posology, route of administration, and frequency, which must be clear and legible. These characteristics of the prescription ensure the safety of the patient and of the professional who performs the administration of the prescriptions (Gimenes et al, 2010). Participants recognize the importance of accuracy, clarity and standardization in prescribing medications as a strategy in medication safety according to the following reports.

*The doctors who are making the prescriptions, absurd, sometimes, that we have to ask, hey, it's like this, hey, it's like this, and who doesn't ask, doesn't do, who asks, does, so, who takes the iron, the patient, you know, so, I don't know, I just gave a continuity, you know, so, to patient safety. (FG3- TEC 7).*

*Regarding this, each member prescribes in a different way and we don't have a standard. Ah, this is a huge problem. They prescribe different prescriptions, even drugs that are not part of the service. (FG3- PHA).*

*[...]but how is the dilution really, because the prescribers were in doubt, the nurses said in the other shift "do it this way", "do it that way", people, how awful, there is no place for us to consult, and then the manual came out, right, so, sometimes we are in a hurry. (FG1- NUR 1)*

*She mentioned magnesium sulfate, I think you were here on the day in relation to sulfate, the prescription was in a way that we are not used to, the doctor, when we talk about patient safety, if you are not having it, you prescribe it, for example, she talked about the protocol there is this way, but here it never was, so, that's the story in a nutshell. (FG3- TEC 7)*

*Because it's not the doctors, it's the on-duty physicians, and I think that this has been the biggest problem that has been happening in the*

*maternity ward, the high turnover, that we don't even know the doctors properly, and they bring them, each one is from a different place, it seems that the maternity ward doesn't have that maternity protocol, and each one brings from a different place, one comes, for example, from another service and brings the one from there, it doesn't match the one here, and it doesn't match. (FG2- NUR 3)*

The error in the medication process is a problem present in healthcare organizations and is pointed out as one of the main causes of adverse events in hospitalized patients. Prescriptions have the potential to cause these errors when incorrectly prescribed. Data such as ambiguity, illegibility, and abbreviations are considered critical points in prescriptions, although the recommendations of the current legislation guide that prescriptions should be legible and clear (Gimenes et al., 2010). In addition to the factors present in the prescriptions, other factors can contribute to errors, because the medication system goes through several steps and several professionals. From prescription to dispensing to patient administration, attention is required at all stages of the process. The probability of errors increases when any aspect of this process goes unnoticed by people in the work environment. This is why it is so important to make the notification or report of adverse events or incidents related to medication in the institution. These reports or notifications are important data for treating the root cause and learning from errors (Fragata & Martins, 2006). It is understood by the participants' speeches, as well as by the literature pertinent to the subject about patient identification and safety in medication administration, that both are valuable strategies to promote patient safety. Furthermore, the participants assimilated this information well, and demonstrated how there were significant changes in posture regarding the goals discussed as a mechanism to promote a culture of patient safety in the healthcare setting studied. Given the context studied, it is noted the importance of investing in all points that relate to patient safety, as well as the process of patient identification, the process of prescription, dispensing, preparation and administration of medicines with the possibility of significant improvements, because the strong point, which is the involvement and commitment of the team, is present in the institution. When relating the quantitative and qualitative data for the analysis of the results, it can be seen that, although the diagnosis of the safety culture of the maternity ward was considered weak, with scores below 75%, there were significant changes in the degree of maturity of the patient safety culture with the implementation of the PSC-MPMB, and this change can be confirmed in the speeches and perceptions of the servers, according to the reports extracted from the focus groups and cited above. Regarding the maturity degree of the patient safety culture, it can be concluded that it has advanced from a pathological maturity degree to the fourth stage, that of the reactive culture. This degree of maturity reveals a culture in which the institution starts to take safety more seriously, but still limited to the occurrence of adverse events. The implementation of the PSC showed the involvement and engagement of the team in the participation and collective construction of the process.

## CONCLUSION

It is concluded that, in the studied institution, the implementation of the PSC reveals changes in the stage of maturity degree of the patient safety culture. It is observed that the institution went from a pathological maturity degree, because it did not have a degree of involvement of the team in relation to patient safety culture in the institution, to a reactive maturity degree. It recognizes patient safety, however, it is a stage in which the actions in the patient safety area in the organization are restricted to adverse event notifications. It is known that the operation of a PSC requires investments in all processes such as team training, materials and supplies, availability of a work team to analyze the root causes and the proper treatment, stimulating, in the institution, the management of adverse events for institutional learning. This study shows a still weakened patient safety culture, signaling the need to strengthen the implemented PSC. It points out the need for operation of the PSC, with more innovative

and efficient management and methodology, with flexible and horizontal proposals that encourage both professionals and managers in their conduct. In addition, it is necessary to develop competencies that encourage the group to add values of a strong patient culture and individual and group behavior patterns in institutions to spread commitment and just culture. Organizations with a positive safety culture are characterized by communication founded on mutual trust through the common perception of the importance of safety and recognition of the effectiveness of preventive measures.

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